

Exploring the accessibility of health care service to Rohingya refugees in Malaysia



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ARTICLE INFO

Article history:

Received 08 November 2020

Received in rev. form 17 Nov. 2020

Accepted 05 October 2020

Keywords:

Innovation

JEL Classification:

L26

ABSTRACT

This paper focuses on social security threats brought by the Rohingya refugees in Malaysia especially on healthcare services. First, a brief historical background of Rohingya ethnic and how this ethnic became refugees is discussed. Secondly, this paper provides a preview of Rohingyas during post Myanmar's political transition. and a short background of Rohingyas in Malaysia. Third, this paper examines on the healthcare services among the Rohingya refugees in Klang Valley, Malaysia and the accessibility of the healthcare.

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Introduction

States in a region today shares borders, territories, security and sovereignty that has to be respect by all nations. States held multilateral relations for its' political and economic development as well as the need to maintain regional harmony. However, in this relationship, states could not escape from international issues involving national interests such as globalization, terrorism, and human rights abuses.

The national security landscape has experienced inclusive dynamics through threats from the cross-border migration process. It is an example of non-traditional security threats to a state. The issue of migration can cause a state to take on social responsibility pressure on humanitarian factors as well as contributing to the deployment of policies based on national security images.

One of the issues is the healthcare services. Healthcare services is important to fulfill ones need for health problem. However, the policy in one's country are not always accessible or supportive. In the case of Malaysia, the Rohingya refugees are facing problem of accessibility to the health care services such as the unaffordable cost, language barrier and poor quality of treatment.

This paper focuses on social security threats brought by the Rohingya refugees in Malaysia especially on healthcare services. First, a brief historical background of Rohingya ethnic and how this ethnic became refugees is discussed. Second, this chapter provides a preview of Rohingyas during post Myanmar's political transition. Third, a short background of Rohingyas in Malaysia is discussed. Finally, this chapter provides information on the healthcare services among the Rohingya refugees in Malaysia and the accessibility of the healthcare.

Historical Background of Rohingya

United Nation considers the Rohingya as one of the world most persecuted minorities. Living in Buddhist dominated nation, they claim that they are the indigenous to Rakhine. However, Rohingya faces human right violation by the army campaign included executions, mass detentions, the razing of villages and systematic rape of Rohingya women since 1962. Force hundred thousand

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them to flee out the country for asylum. They flee to neighboring countries and lives as refugee. Refugees refers to as "one population who immigrated to other countries due to several issue such as war or ethnic cleansing" (Dahlman & O'Tuathail, 2005). The Rohingyas are the Muslim group who was originally settled in the Arakan (Rakhine) area in Myanmar. "*Rohingya*" or "*Rohinga*" or also known as "*Roewengyah*" means "*beloved or loving*". The word is also closely linked to the courage Islamic fighters who served the kings of Arakan in the mid-15th century until the 18th century. (Ahmad, Ghazali, & Abdul Rahman, 2008) The writers also given some thought that "*Rohingya*" is derived from the name of "*Rohang*" which is a mixture of Arabic, Bengali, Urdu and Arakan language. However, the use of Arakan Burman language was higher among this community. The community is mostly resettled in Rakhine (Arakan) of Maungdaw, Buthidaung, Rathedaung, Akyab and Kyauktaw. (Abdullah, 2009) Based on the physical, this community is often misunderstood as people from India or Bangladesh because of their dark skin and physically different from the other ethnic groups of Myanmar. (Abdullah, 1962). According to Myanmar Citizenship Law, groups that are recognize as nationals are Kachin, Kayah, Karen, Chin, Burman, Mon, Rakhine or Shan and ethnic groups as have settled in any of the territories included within the state as their permanent home from a period anterior to 1185 B.E, 1823 A.D.

Burma gained independence on January 4, 1948 and *U Nu* was the first Prime Minister. Starting at that point, Burma practiced fully democratic system of government. People are allowed to vote for their representatives, policy discussed in parliament and there was also freedom of the media publications. In the same year, a citizenship laws were introduced. The law under Article 4 (II) has stated that:

'Anyone who is descended from their ancestors who had lived in the area for at least two generations where their home territory has been consolidated into a single unit or parents or even himself been born in any territory shall be deemed to be a citizen of Burma.' (INGO, 2012).

Although it is not clearly stated that the Rohingya community also fall into this category, but the existence of Rohingya cannot be denied. This had become the main point by the junta government when re-formulating the citizenship law in 1982. In parallel with the drafting of the legislation, *Residents of Burma Registration Act* was enacted in 1949, followed by the implementation of *Residents of Burma Registration Rules* in 1951. Accordingly, the people of Burma have been required to sign up either as permanent residents or foreign nationals. To fix both of these two categories of documents, namely National Registration Card (NRCs) and Foreigners Registration Card (FRCs). NRCs have been given to all residents and foreigners (under Foreigners Registration Act and Rule of 1948) were issued FRCs. There is no third category of people in Myanmar, NRCs has been used as proof of citizenship or nationality. During the administration of *U Nu*, the Rohingya were recognized as Burmese citizens who belong to ethnic minority category. This can be interpreted by a speech made by the Prime Minister himself who said that (Lwin, 2016) the people living in Buthidaung and Maungdaw Township are Rohingya, ethnic of Burma. While the Defense Minister, *U Ba Swe* in the era of his administration also issued a statement in 1959 as follows (Lwin, 2016). The Rohingya has the equal status of nationality with Kachin, Kayah, Karen, Mon, Rakhine and Shan.

In 1961, *U Nu* formed Mayu Frontier Administration (MFA), which includes Maungdaw, Buthidaung and west Rathidaung in northern Arakan. This was announced at the Border Administration Office under the Prime Minister Office that the people living in the Mayu Frontier are Rohingya. Even a Rohingya language program was broadcast by Burma Broadcasting Service (BBS) in Rangoon. The program was broadcast three times a week starting May 15, 1961 and ended on October 30, 1965. Based on such evidence can be seen that the Rohingya people of Burma have been accepted as citizen. However, everything changed after a coup by a military junta government led by General *Ne Win* in 1962. The Junta Government has tried to evoke the feeling of fear of foreign domination in the Buddhist population state. As a result, the Muslim community has been much affected. Muslims have been denied any form of citizenship under the 1982 Citizenship Law which becomes the cause of human right violations towards the Rohingya in Myanmar.

During this era, various steps taken by the Myanmar junta government to eliminate the Rohingya community which is regarded as a problem for the country. This includes the conduct of operations sponsored by the government systematically. Among the significant operations to be focused is *Naga Min* Operation. This operation was aimed at arresting illegal immigrants in Myanmar mainly from the neighbouring countries such as China, Bangladesh, Nepal and India. The purpose of the arrival of these illegal immigrants is none other than to get a job and permanently stay in Myanmar without any valid documents. The migration of foreigners increasingly alarming and uncontrolled mainly from Bangladesh have added more problems in Rakhine. This has led the authorities felt that their crackdown was justified in addressing this issue. Through this arrival, a total of more than 19,457 Bangladeshis are estimated to have entered Myanmar (Dali, 2012).

Naga Min Operation conducted on May 19, 1978 by the government of Myanmar regime in Buthidung and have questioned a total of approximately 198,431 people, while a total of 35,596 people has been subjected to legal action while 6,294 houses were confiscated. A total of 101,048 people had fled from the interrogation in Buthidung and Maungdaw soon as the operation is launched (Dali, 2012). However, this story is only part of the story of *Naga Min* because this operation actually targeting the Rohingyas as victims who certainly do not have identity documents and legal citizenship, and so has made this operation as the most brutal towards the Rohingya community. Another operation began on February 6, 1978 in the largest Muslim village in Rakhine, which is Sakkipara in Sittwe (Dali, 2012) Rohingya community has responded to the government that has made them the target of violence. Further, it

has been used as an excuse by the government to act more ruthlessly on the Rohingya. Finally, this situation has led to the exit of the Rohingya people of Myanmar in large amounts and has made Bangladesh's as one of their destinations.

Rohingya Deprivation of Citizenship

For Rohingya, deprivation of citizenship is the most unfortunate for them. This problem began in the 1960s, during the "Burmanization" campaign led by General *Ne Win*. The campaign has raised the national spirit of the local people, especially Buddhists. Consequently, many Indian and Chinese businesses carried out since the British rule were confiscated. It is estimated around 300,000 Indians and 100,000 Chinese flee and has resulted in shortage of important commodity export business like rice, timber, medicine and petrol (Radford, 2012). To ensure that "strangers" does not return, the government approved the Emergency Immigration Act in 1974. It requires citizens to carry identity card or registration card to facilitate the junta government to identify its citizens. In this case, the Rohingyas are not recognized as citizen, but they only get "Foreign Registration Card" which these cards are not accepted by educational institutions and employers. In 1983, the Burmese government conduct a census among entire citizen of Myanmar following the repatriation of Rohingya refugees from Bangladesh in 1978. (*The Government Could Have Stopped*, 2016). It is also a sequence to the formation of the Burma Citizenship Law of 1982, which excluded Rohingya from the list of ethnic minorities in Myanmar.

Burma Citizenship Law of 1982 has put the citizens of Burma into three categories, namely, (1) Full Citizenship, (2) Associates Citizen, and (3) Naturalized Citizen. Citizenship Code Cards are divided using different colors such as pink, blue and green by citizenship status. According to this law, full citizenship is an individual who belongs to one of the eight groups recognized. In the law there is a clause which states that (Hluttaw, 1982)

'Nationals such as the Kachin, Kayah, Karen, Chin, Burman, Mon, Rakhine or Shan and ethnic groups as have settled in any of the territories included within the State as their permanent home from a period anterior to 1185 M.E., 1823 A.D. are Burmese citizens'

However, the statement does not mention that Rohingya as one of an ethnic group in Myanmar. Following the implementation of this law as well, foreigners can acquire Myanmar citizenship if they can provide evidence that they or their parents had entered and settled in Burma before Burma gained independence in 1948. Individuals with one of her parents hold one of the three types of Burma citizenship was also eligible to apply for citizenship. Besides that, Section 44 1982 Act, individuals who want to get Myanmar citizenship must be at least 18 years old; able to speak well one of the national languages; good character; as well as be a sound mind. Which in this aspect, the Rohingya are not able to claim their citizenship due to Rohingya language with Chittagonian dialect was not recognized as a national language of Myanmar. However, according to the law, only individuals who hold full citizenship are entitled to enjoy the privileges and rights as citizens of Myanmar. This fact is also corroborated by the clause (Calamur, 2012)

The Council of State may decide whether any ethnic group is national or not. The clause gave power for the junta government to deny Rohingya's citizenship even though they have a strong historical background as other ethnic groups. There are injustice towards the Rohingya by denial of citizenship, thus made them as a "stateless person". "Stateless person" is an individual who does not have citizenship, which is the case whether the individual has never acquired citizenship, loss of citizenship or do not have a claim to obtain citizenship of a country (Calamur, 2012). The status of "stateless person" has resulted in the junta government taking measures to repel and eliminate the Rohingya from Myanmar. This includes placing various conditions for restricting their freedom of movement, employment, education, family expansion, health care services and even to obtain basic necessities in life. Safety threats has resulted thousands of Rohingya flee the country to neighbouring countries regardless of direction. They are willing to be displaced by land or sea to have a more secure life.

Besides facing all restrictions from the government, the physical condition of the Rohingya which is very much different from the other people of Myanmar which are very ethnocratic. In this context, the people are ethnocratic towards the ethnic of Bamar and Buddhism. Burmanization policy that was promoted by the government had impacted the Rohingya by being excluded from the society. This policy has also resulted in some of the ethnic minorities in Myanmar, including the Rohingya people feels that their identity was threatened. As for example, International pressure resulted in the military government agreeing to grant the Rohingya a reduced form of citizenship if they registered themselves as Bengali—not Rohingya

Human rights abuses against the Rohingya community is seen due to the "stateless" status who pioneered the other issues. Besides the citizenship issue, the Rohingyas also faced with the issue of ethnic cleansing and slavery are seen to be systematically done by the junta government towards this community since 1982. This had forced them to try and save themselves by fleeing to nearby countries for the sake of survival. This also creates issue of uncontrolled migration to neighboring countries including Malaysia.

Rohingyas during Post Myanmar's Political Transition

After almost 50 years of administration, the Myanmar Junta government finally announced the elections to be held in 2010. The election was boycott by the National League for Democracy (NLD), party that was led by Aung San Suu Kyi. The result of the 2010 election was a formation of a new pseudo-civilian government. The new government is comprised of mostly former military men who had resigned their post to contest under the umbrella of the pro-junta Union Solidarity and Development Party (USDP). On November 13, 2010, the government had unconditionally released Aung San Suu Kyi from house arrest (Calamur, 2012). Since then,

President Thein Sein has begun to initiate democratic reform. Among the efforts are include liberating political prisoners, allowed opposition parties, the National League for Democracy (NLD) to participate in by-elections, eased media restrictions, and opened Myanmar's door to the international community for development purposes. The NLD won 43 seats in by-elections held in 2012, enabling Aung San Suu Kyi to enter parliament and assume a leading role in legislative committees, including one established to revise the constitution (Jones, 2014). These reformations had given hope for Myanmar's people as well as international community that the internal conflict will finally resolve.

The expectation is based on two facts; first, democracy could be able to end the internal conflict as the Rohingya were accepted as citizens before the 1962 military rule. Second, Aung San Suu Kyi as a noble peace prize winner was expected to be able to end the Rohingya issue. However, she was barred from assuming presidency by the 2008 Constitution. The constitutional provision prohibiting Myanmar nationals with foreign marital ties from standing for presidency. On 15 March 2016, U Htin Kyaw was elected as president which was the first civilian president of Myanmar in over 50 years. As the leader of NLD, Aung San Suu Kyi became Myanmar's de facto leader which officially named as "state counselor". Although NLD won a landslide election, the military is guaranteed the right to appoint 25 percent of Myanmar's parliamentary seats, giving it veto power over constitutional amendments. Hence, the army keeps control of Defense Ministry, Home Affairs Ministry and Border Affairs Ministry. These became a reason for the civilian government to be less effective in the face of the crisis.

On 25 August 2017, the Arakan Rohingya Salvation Army (ARSA) which is a Rohingya armed group attacked approximately 30 security force outposts in northern Rakhine State (Myanmar, 2012) ARSA was formerly known as '*Harakatul Yakeen*', first emerged in October 2016 when they attacked three police outposts in the Muangdaw and Rathedaung townships (ARSA, 2017a) According to the European Center for the Study of Extremism, Maung Zarni, ARSA's action were borne out of "systematic abuses of genocidal proportions" by the Myanmar military. They are not a terrorist group aimed at striking at the heart of Myanmar society as the government claims it is. They are a group of men who decided to form a self-defense group and to protect their people. The ARSA said that they have no links with al-Qaeda, the Islamic State of Iraq and the Levant (ISIS), *Lashkar-e-Taiba* or any other transnational terrorist group (ARSA, 2017b) This statement could be trust since these men are not well equipped. All they have are sticks, swords and guns they seized from military outposts (ARSA, 2017a) Due to the August 2017 ARSA attack, there were more than 520,000 Rohingya flee to neighboring Bangladesh (International, 2018)

International community was waiting for "new" Myanmar government to explain the issue. After 25 days of attack on the Rohingya villages, Aung San Suu Kyi was finally making a public statement. Unfortunately, she did not blame the Myanmar's military action. Instead, she blamed "a misinformation campaign" wide spread. Her government, she said, was "concerned" about reports of villages burning in Rakhine, but had to weigh "allegations and counterallegations" before acting. She argued that the international community should pay more attention to areas where there was peace than areas where there was conflict (Dias, 2017) This suggests that Suu Kyi had never sided with Rohingya and did not show any interest in helping them. It has *also destroyed the hope of Rohingya to regain their rights as a resident of Rakhine*.

An Outlook of Rohingyas in Malaysia

Malaysia has not ratified the 1951 UN convention relating to the status of refugees and its 1967 optional protocol relating to the status of refugees. So, the government does not provide protection or assistance to refugees. Besides that, Malaysia does not legally receive, register, document or conduct refugee status determination for the refugees. Thus, Malaysia immigration law and policy view the stateless, refugees, asylum seekers and irregular through the same lens. Freedom to move is one of the human right, however, as a refugee, the freedom to move among Rohingya is limited in Malaysia. They are facing with the risk of being caught by the police or other special force. This is because, they are thought to be illegal to stay in Malaysia which therefore could influence the socioeconomic income among Malaysian citizen. Therefore, the other human right is also being restricted to them including the access to health care services, employment, and education.

In Malaysia, refugees are dispersed throughout the country with most of them living in the Klang Valley. As illegal immigrants under UNHCR security they lived in low cost flat, construction sites and make shift camps in the jungle (Low, Kok, & Lee, 2014). Lacking of legal status, the refugees need to face many life challenges to meet their own survival needs. Most of them work in restaurants, construction sites, plantations, vegetable farms and other odd jobs to earn their living. They lived in constant fear which always in the move to avoid detection by the immigration officers. For those under the protection of UNHCR they lived in community centers which include informal schools for the children (Low et al., 2014)

The refugees flee into Malaysia by overcrowded boats run by smugglers in Thailand. They faced with lack of sufficient food, water and also being abused verbally and physically. Some of the children were kidnapped by the smugglers before they could reach Malaysia. In addition, there were tortured, sold into slave labor and forced to borrow large sums of money to pay smugglers (BBC, 2015). Therefore, many refugees arrived in Malaysia being traumatized, sick and owing huge debts to family, friends or smugglers. The refugees and asylum- seekers who were registered with UNHCR in Malaysia were 58,519 until February 2016 (Betts, Bloom, Kaplan, & Omata, 2014). It is considered as urban population as there are no refugee camps in Malaysia. The majority of refugees are concentrated around the capital Kuala Lumpur and Klang Valley instead of Penang Johor and Malacca. Table 1 shows the total number of refugees in Malaysia. Table 1 details that there were 135,740 refugees from Myanmar, 69,880 are registered as Rohingyas

compared to other ethnics such as Chins (33,020), Myanmar Muslims (9,820), Rakhines and Arakanese (4,020) and other ethnics (UNHCR, 2018). The statistic clearly shows that Rohingya is the largest group of refugees in Malaysia.

Table 1: Normality

Country	Total Persons of Concern
Myanmar	135,740
Pakistan	5,690
Yemen	2,720
Syria	2,550
Somalia	2,520
Sri Lanka	1,940
Iraq	1,470
Afghanistan	1,380
Palestine	750
Other countries	1120
Total	155,880

Source: UNHCR Report (2018)

Malaysia does not have a legal, policy or administrative structure for reacting to refugees including receive, register, document or conduct. The Malaysian government does not offer direct security, protection or assistance to refugees on its territory (Crisp, Obi, & Umlas, 2012). Therefore, refugees in Malaysia have been continuously at risk of arrest, detention, extortion and corporal punishment although the number of such incidents has diminished in recent times. They face official restrictions from working in the formal sector, accessing healthcare and attending Malaysian schools (Cheung & Cheung, 2011). Therefore, they are frequently expressed and experienced the feeling of being helpless, powerless, fearful and sad. As consequences, this experience of discrimination might lead to increase the levels of chronic health problems, depression, physical disabilities, and poor psychological well-being. (Low et al., 2014)

Although Malaysia has ratified all the fundamental ILO Conventions, refugees in Malaysia are prohibited from employment in the country. As “illegal immigrants”, refugees have no legal status to work. Persons who employ, house or harbor them are also subject to severe penalties. However, in order to survive, these refugees do take up informal employment. Without a legal status, they have no choice but to work in hazardous, poorly paid and with no protection. The most common employments among Rohingyas men in Malaysia are vegetables seller in the market, construction labor, cleaners and scrap collector. They are exposed to the possibility of not receiving salary from employer, being detained by the authorities, being abused and exploited as receive no legal recourse or complaint mechanism. Other than that, they also face the risk of job accidents due to poor safety procedures for refugees which could result them occurring serious physical injuries. High risk of employment with low salary rate affect their affordability in obtaining health care services in Malaysia.

The housewives stay at home to take care of their children. They rarely go out as it is not a normal culture for Rohingya women to work outside. Normally, there are more than one family who stay in one house to share monthly rental and utilities. They may stay in the community of local people as they rent the house within the city area. Crowded household causes other problems such as sanitary and wastage management. The poor hygiene routine increases the risk of infectious diseases such as tuberculosis, hepatitis, diarrhea and Malaria. Besides that, the Rohingyas are free to practice their religious routine such as praying in the mosque, celebrating religious event or even participate in the community social events. They are not restricted by Malaysia force to practice their religion routine unlike in their origin country where all the mosque and religious center being destroyed and fired by the military force of Myanmar. In Malaysia, they are safe to stay in the house. Moreover, the women are not restricted to get pregnant and deliver. They can easily decide how many children they want without limitation. Besides that, there are no restrictions on the food supply to them. There are able to go to market and grocery shop to buy for food unlike in their origin country where food is very limited.

Health Care Services among Rohingya Refugees in Malaysia

Maintaining health is compulsory for everyone and providing health services is the government’s responsibility of a country. It is no exception for refugees residing in Malaysia. This is important for them to have optimal health to maintain productive to survive in residing country such as Malaysia. It is common to see that the prolong illnesses due to untreated fever or influenza infection may affects the physical ability and performance to perform daily routine and task at work. Prolong bed rest also increase other health risk and complication such as infections and body pain. According to the Refugee Convention, refugee should not be discriminated

in obtaining any service in a host country which include health services (Hammond, 2004). However, based on the Refugee Health Technical Assistance Center (RHTAC), the health services given to Burmese refugees in Malaysia are still limited. Although the Malaysian government did take few steps as an effort to help the Rohingya refugees in improving and maintaining their health condition, it is viewed as limited. These efforts are still inadequate and not fully implemented and sustained. In fact, health care policy towards refugee seen as restriction of access to health care services. This is based on grew observations on accessibility.

Penchansky and Thomas (1981) introduced five dimensions of access to health care. First dimension is **availability** which denotes the association between supply and demand of available health service. The availability of the health services in the participants living area such as hospital, clinic or pharmacy may contributes to the high rate of medical visits. There are two main government hospitals in the area which are Tengku Ampuan Rahimah Hospital in Klang and Hospital Besar Ampang in Ampang, Selangor. The other private medical hospital is such as hospital KPJ Klang and KPJ Ampang Puteri in Ampang. It is not included the other health care premises such as clinics and pharmacy that is mushrooming in the city area. In addition, most of the clinics is open in 24 hours in 7 days which is ready to receive patients at any time. However, the study was conducted in the urban area. Question rising if the rural area where the health services limited which definitely requires high cost, time and accessibility to seek the services. However, statistics was found that most of them were live in the semi-urban area where the medical premises available and mushrooming. Therefore, availability of the medical premises is not a major issue in Malaysia as the premises is highly available for the citizen and foreigners. Besides that, in the city area, the opportunity of vacancy or employment is high such as in the market or groceries area as found in this study. This could increase their affordability to obtain the services. Most of the participants were also claimed that there was no availability problem when they want to seek for medical services compared to their origin country. In addition, the high frequency of medical visits was also due to efficient services of the health services in giving the right treatment and medicine to cure their illnesses.

Second dimension is **accessibility** which refers to the location of supply of service and the location of clients, taking account of client transportation resources and travel time, distance and cost. In term of accessibility, this study was also found that there was no transportation barrier among the participants to obtain the medical services. None of the subjects claim the transportation was because of the transportation's barrier. More than 50% of the participants do have motorcycles as their main transport when compare to car and or bicycle. In addition, the two main hospitals are located nearby the subjects living area, there are also private clinics and pharmacy that given them choices to get proper treatment and medication. They can have obtained the services at anywhere and anytime without any restrictions and discrimination in Malaysia as to compare with their origin country. Despite of that, the good services of the public transportation in Malaysia such as train, public bus and taxi were one of the factor which contribute to the high rate of medical visits among Rohingya in Malaysia. One of the participants said that he prefers to go to the hospital by public bus which only cost him RM2.00. In addition, certain health premises were located near the living area of the refugees where the distance is only 'walking distance' where they can access easily without any restrictions or barrier.

Third dimension of access to health care introduce by Penchansky and Thomas is **accommodation**. There are still room for improvement to increase the access to health care for Rohingya refugees. Although there were no complicated procedure and bureaucracy to obtained health care services were reported. The participants basically accepted the accommodation provides by Malaysian health care practitioner. Except for long waiting hour in government hospital which makes them prefer to seek health care services in the private hospitals or clinics. Although the cost is higher, they still could afford the services provide by private hospitals because it is reported that there is not much different in term of charging. Other than that, one of the participants also share his experience of keep being transferred from bed to another bed because the government hospital was lack of bed available in ward besides agreed to the long waiting hours in the emergency department.

The other factors that may influence the rate of health care visits are the **affordability** to pay the health care services' cost. Affordability are also one of the dimensions in the theory of access. This study found that most of the participants had problem with the health care cost but they could still afford to pay for simple illnesses. Although acquired a 50 per cent discount from initial cost, refugees with UNHCR card still facing problem to pay for such services as they could not get a legal job in Malaysia. The Rohingyas be able to only get a low-income job such as market helper, scrap collector, 'Madrasah' Teacher and tailor. The salary range of the job were mostly below than RM900 which is not sufficient for them to spent on medical fees. The amount of salary is known to be unsufficient particularly in the urban area where the place Rohingya stay the most. In addition, concern raise if they had face complicated cases which requires complicated intervention such as surgery and chemotherapy. Furthermore, most of them do not possess any medical insurance coverage to obtained high cost medical treatment in Malaysia. Therefore, they may suffer for prolong illnesses and chronic diseases due to lack of proper medical treatment. The low-income status is one of the reason to put them in dilemma to not prioritize the medical treatment rather than food, house rental and utilities bills.

Although this study found that the refugee could still afford to pay for simple illnesses, more study need to be conducted to explore their experiences when they had to seek medical attention for severe illnesses such as tumor or cardiovascular diseases. The affordability should different for simple and severe illnesses such as fever, cough and tumor respectively. The salary range of the job among them was found to be sufficient for them to afford the medicine and health care services, however, there is some financial limitation and restrictions for the expert and sophisticated treatment for severe illnesses. Unfortunately, beginning in January 2015, health care service charges for foreigners has increased gradually to 100 percent in 4 years of time. This had made the 50 percent discount given to UNHCR refugee seems to be no advantage. It can be seen that the Malaysian government is putting effort to help

the Rohingya refugee in improving or maintaining their health condition. However, these efforts are still inadequate and not fully implemented and sustained.

The fifth dimension in theory of access are **acceptability** which refer to “an acceptable service projected by the attitude of the provider and the consumer regarding characteristics of the service and social or cultural concern”. Although this study investigating the experiences of Rohingya when seeking medical services, more study should be conduct to obtain the experiences of medical staff when dealing with refugees particularly Rohingya. At any reason or situations, the medical staff in Malaysia should give the best services without any discriminations towards them. This is the policy or work mechanism among Malaysian citizens as we are a multiracial country where discrimination is something uncommon to be practice in Malaysia. Indirectly, the positive attitude putting aside racism and discrimination could be the advantage for refugees to stay and obtain health care services in Malaysia. This shows that Malaysian citizen have high acceptance level on refugees and not preaudits towards other race in this multiracial country. Despite of any unsatisfied services in the health sectors either private or government, the medical services in Malaysia is far better towards them when compare to their origin country.

Lastly, the dimension added by Emily (2016) which is **awareness**. Awareness and knowledge on health are other factors that contribute to the high rate of medical visits. This study shows that the low education status had no relation with the medical visits as sickness is naturally enforced human to seek for medical attention such as clinic, hospital or pharmacy. Besides that, language literacy particularly Malay language may increase the communication between the Rohingya and medical staff, this may maintain the rapport and effective education towards Rohingya by the medical staff. Besides that, the language proficiency may ease the business between the refugees and the medical staff. This is important to ensure the smoothness of the services to give the right treatment for the right condition of the diseases and illnesses. The factors that may contribute to the rate of health care visits shows positive environment and performance of medical services towards refugees and foreigners in Malaysia. This may helps UNHCR to focus on refugees’ resettlement as Malaysia had proven to give their best support on refugees quality of life.

According to Leon (2002), dimensions of access to health care form a chain that is no stronger than its weakest link. All the dimension should be address at once since not one dimension is greater or important than the other dimensions. Thus, from this study we could see that access to health care towards Rohingya refugees in Klang Valley fulfill three out of the five dimensions introduce by Penchansky and Thomas (1981), namely availability, accessibility and acceptability. However, there are still complaints toward the other two dimensions which are accommodation and affordability. Accordingly, the access to health care towards Rohingya refugees in Klang Valley are still low and needs improvement.

Conclusion

Over all, the Rohingya refugees in Klang Valley are satisfied with the health care services in Malaysia. There are no negative complaints received on the availability of healthcare services since refugees are allowed by the Malaysian government to get health care treatments. The health premises including clinics and pharmacies are also available in anywhere in Malaysia. In fact, there are mushrooming in the city and semi-urban area. However, there are still room for improvement in terms of accommodation and affordability of refugees in getting access to health care services. The Malaysia government also have to bear with the various issues such as cost to meet the health needs of these groups. In 2018, the cost of health care towards foreigners had been increased into 100 percent. Malaysia is aware that the hike in the medical cost would bring more problems such as contribute to the low rate of medical visit among refugees and subsequently increase the risk of spreading diseases among local community. This is where Malaysia has to work with other organisation such as UNHCR and other NGO’s in ensuring the basic healthcare of refugees are taken care.

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